Testimony by

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Mr. Chairman:

Thank you for inviting me to testify today. Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care.

I would like to address two of the central features of the Bush Administration's response to the problem of the uninsured – the promotion of section 1115 waivers to states to expand health coverage through the Medicaid and the State Children's Health Insurance Program (SCHIP) and individual tax credits.

Section 1115 Medicaid and SCHIP Waivers

Families USA has been engaged in issues affecting the Medicaid program throughout our 20-year organizational history. Medicaid is an essential program that provides comprehensive, affordable health coverage to over 40 million Americans.

In August 2001, the Bush Administration released a non-regulatory guidance document to the states describing its new waiver initiative known as the Health Insurance Flexibility and Accountability (HIFA) initiative. The HIFA initiative has been widely advertised by the Administration as a way to expand health coverage and reduce the numbers of uninsured Americans.

While we applaud the Administration's desire to address the growing numbers of uninsured persons through public programs, we have a number of concerns about this new policy that I would like to share with you today. The most fundamental problem with the Administration's strategy is that no new federal money is provided to cover the uninsured. Financing comes primarily from one of two sources – existing, unused SCHIP funds or reductions in health benefits currently received by program beneficiaries.

While some states currently have a surplus of SCHIP funds, this in part reflects the fact that the program, which started very recently, is still in the process of "ramping up" as more and more families become aware of it. Unfortunately, just as the program is ramping up, and at a time when SCHIP coverage is of greater importance due to health coverage losses resulting from job layoffs, less money will be available for children's health coverage.

When SCHIP was enacted in 1997, the projected bleak budget forecasts for fiscal years 2002-2004 resulted in lesser funds being made available for the program during that time than in the years preceding 2002 and in the years following 2004. As a partial result of this so-called "SCHIP funding dip," the Administration projects that 900,000 children will lose SCHIP coverage between fiscal years 2003 and 2006.

To exacerbate this problem, the Administration is approving diversions of SCHIP funds away from low-income children and towards other population groups. We believe that this policy is shortsighted and that funding for expanded coverage to adult populations should come on top of, not in lieu of, health coverage funds for low-income children.

The second option created by the new waiver policy is even more troubling – namely, reductions in services to current Medicaid beneficiaries. The Administration is urging states to support health coverage expansions by cutting back their commitments to people and families who currently depend on Medicaid as their health coverage lifeline. Since the Administration is very strictly adhering to a policy that waivers should result in no added expenditures, this means that the poorest of the poor – those already eligible for Medicaid – will be forced to experience program cutbacks.

The cutbacks encouraged by the Administration include: reductions in health benefits; increases in cost sharing; and elimination of the guarantee that all eligible persons receive coverage. These types of changes and cutbacks in services were extensively debated – and rejected – when Congress and President Clinton considered changes to the Medicaid program in 1995 and 1996. In effect, therefore, the Bush Administration proposes to restructure the Medicaid program to the detriment of current beneficiaries through the "back door" of waivers that implement policies that were rejected, and I believe would be rejected again, through the "front door" of Congressional action. We believe that it makes little sense to allow harmful Medicaid restructuring through administrative fiat that would not pass through the legislative process.

The Administration has encouraged all of the states to apply for these waivers; has developed a template for the submission of these waiver requests so that as many states as possible can submit them; and has indicated that waiver requests will be granted on an expedited basis. Such a wholesale restructuring of Medicaid was never contemplated when the 1115 waiver system was created by Congress. That waiver system was designed for unusual experimentation in specific situations to test new concepts and approaches, not to eviscerate basic program protections established by federal law.

To make matters worse, the promotion of this waiver initiative occurs at a time when states are experiencing fiscal crises that are prompting their desire to cut back the Medicaid program. For many states, this waiver initiative constitutes a license to cut spending for current beneficiaries without a concomitant and commensurate commitment to channel those savings to uninsured populations. Indeed, there is no explicit federal

policy that requires and monitors that cost savings be directed at coverage expansions. We already know that one state has proposed cutbacks only and others are expected to do the same. At best, therefore, the waiver initiative is a zero-sum game; at worst, it constitutes a major cutback in funding public health coverage for America's most vulnerable populations.

To compound the problems that I have described, these waiver initiatives – that are likely to change, in a very harmful manner, the protections accorded to low-income beneficiaries – are being decided without public input. Indeed, the waiver applications submitted by the states are often totally unavailable to Medicaid stakeholders until after decisions are reached about the waiver applications.

A federal notice published in the Federal Register in 1994, among other things, requires that there be an opportunity for public input and comment by all stakeholders at the state level before a state waiver application is filed with CMS. Not only is this requirement being ignored at the federal and state levels, but CMS is also refusing to give copies of waiver applications to stakeholders requesting such copies even after the waiver applications have been officially submitted. In effect, therefore, major re-structuring of the Medicaid program is happening not only without Congressional oversight, but without public input – and outside of the public's purview.

The following are some of the substantive problems that are arising from these waiver initiatives.

Reductions in benefits and cost sharing: The HIFA policy is premised on allowing states increased flexibility to reduce benefits and increase cost sharing for current program beneficiaries. The policy, as stated in the CMS guidance of August 2001,

will allow states to move Medicaid beneficiaries who are in so-called "optional" categories – i.e. beneficiaries whom states are not required under federal law to enroll in the Medicaid program – to receive fewer health benefits than they are receiving today. Those beneficiaries will receive coverage based on the benefits package defined in the SCHIP statute. That statute allows states to create a benefits package (that the Secretary of HHS approves) that provides significantly fewer services. For example, in Utah's approved waiver, parents with incomes between 55 and 150 percent of poverty (between $8,261 and $22,530 in annual income for parents in three-person households) will receive only primary care – no specialty care or hospitalization is covered.

In addition, with one exception, these "optional" beneficiaries will no longer be protected by limitations in cost-sharing obligations. That exception involves children in "optional" categories, and their cost-sharing cap will be five percent (5%) of their family income; that cap in cost sharing, however, will not apply to adults in the same family who are also covered.

Unfortunately, there are 11.7 million low-income people who are currently considered "optional" Medicaid beneficiaries – and these people can ill afford an increase in cost sharing or a loss of health benefits. Forty-three percent (43%) of low-income parents currently covered by Medicaid are considered "optional" beneficiaries; their incomes are, on average, above 41 percent of the federal poverty line ($6,158 in annual income for a family of three). Thus, the cutback in program benefits and increases in cost sharing will undoubtedly constitute a severe hardship.

Similarly, 56 percent of seniors currently covered by Medicaid are considered "optional" beneficiaries since states are only required to cover seniors and people with

disabilities if their individual incomes fall below 74 percent of the federal poverty line – a meager $6,556 in annual income. Since the incomes of these beneficiaries are so low, and because their health care needs tend to be greater, a decrease in their benefits is likely to mean a decrease in usage of needed health care services.

Moreover, despite the Administration's claims that "mandatory" beneficiaries will not see a reduction in benefits, the state of Utah recently received approval to raise cost-sharing and reduce benefits for "section 1931" parents, a mandatory coverage group in the Medicaid program. These very poor parents, whose incomes fall below 55 percent of the federal poverty level ($8,261 in annual income for a family of three), will now be required, among other things, to pay $100 per day for hospital coverage. We know, however, based on extensive research, that low-income persons faced with such substantial cost-sharing obligations are unable to pay for, and hence forgo, needed health care.

For the "expansion," or newly covered, groups in Utah, the Administration has approved an extremely slim benefits package that would not include inpatient coverage or specialty care. The approved Utah waiver for this group of childless adults and newly covered parents only includes primary and preventive care services. In effect, this benefits package would allow a woman to go to her primary care doctor, be diagnosed with suspected cancer, and be unable to see an oncologist, have surgery or other treatment to treat the cancer. In effect, this is health insurance coverage that provides precious little coverage and that will result in enormous frustration for low-income people.

Premium assistance: Despite an emphasis on state flexibility, the Administration is apparently requiring states to include a so-called "premium assistance" component in any HIFA waiver request – even if a state does not initially wish to do so. "Premium assistance" is a policy that allows Medicaid to pay for low-income workers' premiums for employer-based health coverage. Although it makes sense to enable Medicaid beneficiaries to participate in their employer health plans, it would be inappropriate that such federal subsidization of employer health coverage be provided without reasonable standards concerning such coverage. Yet, under the Administration's new HIFA waiver system, such standards are being eliminated.

Before the new HIFA waiver policy, states were permitted to support employer-based health coverage through Medicaid but had to comply with federal rules concerning the benefit package and cost sharing. These protections were established so that Medicaid beneficiaries would not be channeled to Medicaid-funded, employer-provided health plans that are significantly inferior to regular Medicaid coverage. Unfortunately, the Administration is now willing to waive all cost-sharing and benefits requirements for low-income people who will channeled into premium assisted, employer-provided health coverage. In addition, the HIFA guidance makes clear that rules on cost-effectiveness – which required that states spend no more on premium assistance than it would have spent by enrolling the individual or family in Medicaid or SCHIP – will be loosened. As a result, states could end up spending more to enroll an individual or family in private insurance, thereby spending more to provide less coverage for the affected people.

Enrollment caps: An essential feature of the Medicaid program is that an applicant who meets the eligibility requirements will be guaranteed the health coverage

that they seek. The use of enrollment caps undermines this guarantee of services. The Administration's August 2001 guidance does not explain what its policy will be on enrollment caps, yet the waiver application template includes a box for states to check if they wish to request an enrollment cap. The recently approved Utah waiver included such a cap for expansion groups.

Our biggest concern about the use of enrollment caps is that they are arbitrary in nature. A state is already permitted to roll back eligibility for optional categories in the Medicaid program, and such a rollback, while potentially harmful, at least ensures that the lowest-income beneficiaries will continue to be served. An enrollment cap, on the other hand, means that a parent with income at 125 percent of the federal poverty line could come in on a Tuesday and receive services – and, if enrollment were closed on Wednesday, a parent with income at merely 60 percent of the federal poverty line would be denied services if she applied on Friday.

Financing: The August 2001 guidance and subsequent public statements by the Administration have underscored the Administration's interest in promoting a "per capita cap" arrangement in the financing of Medicaid. We, along with the National Governors' Association, have opposed efforts to impose per capita caps in the past. A per capita cap creates an artificial and arbitrary upper limit on federal contributions to the program that may or may not reflect actual need. Such a cap does not allow for increased costs due to new technologies, increased use of services, or high-than-expected medical inflation.

In addition, the recently approved Illinois drug waiver includes a global expenditure cap, not just on drug costs, but on all services received by all seniors through the Medicaid program. This cap means that, should drug prices escalate higher than

expected, the poorest seniors could see reductions in their services. For example, if drug costs escalate higher than expected for seniors whose incomes are between 100 and 200 percent of the federal poverty level, then seniors whose incomes are below 100 percent of the poverty level could see their hospital days reduced or doctors' visits limited in order to stay within the expenditure cap.

With respect to state financing of the waivers, all of the expansions approved so far have been contingent on the availability of state funds. This is an obvious reality, but it raises a very important question. If, for fiscal reasons, states choose not to implement their approved expansion, or they enroll considerably fewer persons than initially promised, will they still be permitted to implement the cutbacks to current beneficiaries that CMS has approved? Obviously, if they are allowed to implement those cutbacks, the result may be a significant net reduction in health services to low-income people and families in those states.

Tax Credits

The President did not propose more funds for Medicaid expansion in his FY 2003 budget. Rather, he proposed the enactment of individual tax credits to help the uninsured purchase coverage. This proposal allows a refundable credit against federal income tax liability to defray all or part of the cost of purchasing coverage in the private, individual health insurance market. The President's proposal would provide a tax credit of up to $1,000 for an individual or up to $3,000 for a family. This tax credit would be available only to those who do not have insurance coverage through their employers and who are not eligible for Medicaid. It also limits the full credit to individuals with incomes under $15,000 and families with incomes under $25,000.

To find out what such a tax credit would mean for low-income people who are uninsured, Families USA gathered and analyzed information about insurance plans offered in the following 25 states: Alaska, Arizona, Arkansas, California, Florida, Illinois, Iowa, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, and West Virginia.

In our report, *A 10-foot Rope for a 40-foot Hole: Tax Credits for the Uninsured* (September 2001), Families USA identified the health insurance plans available in the individual market for in the largest city in 25 diverse states. The study used eHealthInsurance.com to identify plans in 20 states. For the four states where information was not available through eHealthInsurance.com, the study used QuoteSmith.com. In the case of Vermont, Families USA contacted health insurance companies directly.

We identified plans available for a premium of no more than $90 per month ($1,080 annually). When more than one plan was available in this price range, we chose the best plan by applying the following criteria, in descending order of importance: 1) having the lowest deductible; 2) having the best coinsurance rate for inpatient and outpatient services (with no more than 20 percent paid by the insured individual); and 3) offering some coverage of doctors' office visits.

The study used two hypothetical applicants—a 55-year-old woman and a 25-year-old woman. Both hypothetical applicants were healthy non-smokers and, as such, were favorable prospects for coverage. Information was sought on plans that cost approximately $1,000, the maximum amount of the tax credit for an individual. The data

gathered by this study allowed us to answer the question: What kind of coverage can be purchased in the individual insurance market with a $1,000 tax credit?

Our analysis found that, in many cases, $1,000 plans were simply not available. When they were available, the $1,000 plans generally provided incomplete coverage, had high deductibles, and required high coinsurance or copayments. These findings apply to plans available to the healthiest applicants. Applicants who have health conditions would be even less likely to find any plan available. Moreover, plans offered to such applicants would restrict coverage for services related to their health conditions and/or charge significantly higher premiums.

$1,000 health plans are often not available for healthy, non-smoking, 55-year-old women. In 18 of the 25 states, no plans were available for a healthy, non-smoking, 55-year-old woman. Those states were Alaska, Arkansas, California, Florida, Illinois, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Jersey, New Mexico, New York, Pennsylvania, South Dakota, Texas, Vermont, and West Virginia.

$1,000 plans for healthy, non-smoking 55-year-olds are substandard. In the seven states that had $1,000 plans available for a healthy, non-smoking, 55-year-old woman (Arizona, Iowa, North Dakota, Oklahoma, Oregon, Tennessee, and Utah), the coverage offered was substandard.

The deductibles were very high. In five of these seven states, the deductible was $5,000; in two states, the deductible was $2,500.

Other out-of-pocket costs were very high**.** For example, in six of the seven states, the coinsurance rate was higher than 10 percent. The annual limit on out-of-pocket

spending was higher than $3,000 in six of the seven states (the highest was $10,000 in Oregon).

The coverage offered by these plans was very limited. Doctor's office visits were not covered in three states and were deficient[1] in the remaining four. Prescription drugs were not covered in six states and were deficient in one. Emergency services were not covered in three states and were deficient in the remaining four. Inpatient hospital services were deficient in six states. Mental health care were not covered in six states and were deficient in one

$1,000 plans are not always available for healthy, non-smoking, 25-year-old women. In six of the 25 states, no plans were available for a healthy, non-smoking, 25-year-old woman. Those states were Maine, Massachusetts, New Jersey, New York, Vermont, and West Virginia.

$1,000 plans for healthy, non-smoking 25-year-olds are substandard. Although $1,000 plans were available for a healthy, non-smoking, 25-year-old woman in 19 states (Alaska, Arizona, Arkansas, California, Florida, Illinois, Iowa, Louisiana, Mississippi, Montana, New Mexico, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, and Utah), the coverage offered by those plans was substandard in every case.

The deductibles charged for these plans were high. Deductibles ranged from $500 (in five states) to $5,000 (two states).

[1] "Deficient," for the purpose of this analysis, means the plan provides lesser coverage than a "standard" health plan—defined as comparable to the most popular plan offered under the Federal Employees Health Benefits Program's Blue Cross/Blue Shield Standard Preferred Provider Organization plan (FEHBP BC/BS PPO).

Other out-of-pocket costs were very high. For example, the coinsurance rate was higher than 10 percent in seventeen of the nineteen states. The annual out-of-pocket limit was higher than $3,000 in seven of the nineteen states (the highest was $7,000 in Montana).

The coverage offered by these plans was very limited. Doctor's office visits were not covered in four states and were deficient in thirteen states. Prescription drugs were not covered in six states and were deficient in twelve states. Emergency services were not covered in four states and were deficient in the remaining fifteen states. Inpatient hospital services were deficient in all nineteen states. Maternity care was not covered in eighteen states and was deficient in one. Mental health care was not covered in seven states and was deficient in remaining twelve states.

It is clear, therefore, that the individual tax credits offered by the Administration will provide for too little help to make health coverage affordable for low-income people.